2020 Health History and Examination Form

For Camp Use Only
Cabin # ____

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. The health history portion must be filled out by parents/guardians of minors or by adults themselves. Additionally, a medical exam is required within 12 months of the camping session. If an exam was already done in that time period, your physician may be willing to fill out the form without an additional examination. The medical exam form on the last page must be completed and signed by approved licensed medical personnel.

COMPLETED FORM IS DUE BY JULY 1, 2020 - PLEASE MAKE A COPY OF THIS FORM TO KEEP ON FILE FOR YOUR OWN REFERENCE.

Completed forms may be scanned and emailed to **info@campstherman.org** or
mailed to the *Camp St. Herman Administrative Office at* **5 Delaney Drive, Walpole, MA 02081**

Name: ____
Last First MI

Age while attending camp: ________ Date of Birth: ________________ Gender: ☐ Male ☐ Female

Home Address: ____
Street Address City State/Prov. Zip

Custodial parent/guardian(s):

Name ________________ Phone: (h)______________ (w)______________ (cell)______________

Name ________________ Phone: (h)______________ (w)______________ (cell)______________

Other Emergency Contact Name: ______________________ Home Phone: ______________

Relationship to Camper : ______________________ Other Phone: ______________

Name of family physician ______________________ Phone: ______________

Name of family dentist/orthodontist ______________________ Phone: ______________

Is the participant covered by family medical/hospital insurance? (*Please check one of the boxes below*)
A photocopy of the __front and back__ of your health insurance card must be attached to this form.

☐ Yes Carrier or plan name: ______________________________

Group #: ______________________ I.D. #: ______________________

Insurance Holder's Name: ______________________ Date of Birth: __________

☐ No

Health History & Information

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival to camp. Please provide complete information so that the camp can be aware of your health needs.

Which of the following has the participant had?

☐ Measles
☐ Chicken Pox
☐ German measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test
Date of last test _______
Result: ☐Positive ☐ Negative

__PLEASE GIVE DATES OF IMMUNIZATION FOR:__

DTP ______________________
Tetanus ______________________
Tdap ______________________
Polio ______________________
MMR ______________________
or Measles ______________________
or Mumps ______________________
or Rubella ______________________
Haemophilus influenza B ______________________
Hepatitis B ______________________
Varicella (chicken pox) ______________________
Meningitis ______________________

☐ My child is not immunized (medically exempt or religious/moral exemption)

ALLERGIES **Describe reaction and management of reaction**

Medication Allergies

____________________ ____

____________________ ____

Food Allergies

____________________ ____

____________________ ____

Other Allergies (include insect stings, hay fever, asthma, animal dander, etc.)

____________________ ____

____________________ ____

MEDICATIONS CURRENTLY BEING TAKEN (Meds brought to camp *must* be in their original labeled pharmacy container.)

Med #1 ____________________ Dosage __________ Specific times taken each day ______________

Reason for taking ____

Med #2 ____________________ Dosage __________ Specific times taken each day ______________

Reason for taking ____

Med #3 ____________________ Dosage __________ Specific times taken each day ______________

Reason for taking ____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: ______________

____

OVER-THE-COUNTER MEDICINES (OTC Medications are given according to package instructions indicated for the camper's age)

Please circle Yes or No next to each over-the-counter medication that your child is permitted to take.

Antacids	Yes	No	External Ointments, Sprays, & Lotions	Yes	No	Pepto Bismol	Yes	No
Antiseptic Throat Spray	Yes	No				Sterile Eye Irrigate	Yes	No
Benadryl	Yes	No	Ibuprofen/Aleve Products	Yes	No	Sudafed	Yes	No
Cough/Throat Lozenges	Yes	No	Midol (females only)	Yes	No	Tylenol Products	Yes	No
Cough & Cold Products	Yes	No	Mucinex Products	Yes	No	Products for Constipation	Yes	No

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness, or disease?…….	☐	☐
2. Have a chronic or recurring illness/condition?…	☐	☐
3. Ever been hospitalized?…………………………	☐	☐
4. Ever had surgery?…………………………………	☐	☐
5. Have frequent headaches?………………………	☐	☐
6. Ever had a head injury?…………………………	☐	☐
7. Ever been knocked unconscious?………………	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?………………	☐	☐
10. Ever passed out?...………………………………	☐	☐
11. Ever been had episodes of dizziness?...………	☐	☐
12. Ever had seizures?………………………………	☐	☐
13. Ever had chest pain during or after exercise?…	☐	☐
14. Ever had high blood pressure?…………………	☐	☐
15. Ever been diagnosed with a heart murmur?…..	☐	☐
16. Ever had back problems?………………………	☐	☐
17. Ever had joint problems (i.e., knees, ankles)?……………………	☐	☐
18. Have an orthodontic appliance being brought to camp?…………………	☐	☐
19. Have any skin problems (i.e., itching, rash, acne)?………………	☐	☐
20. Have diabetes?……………………………	☐	☐
21. Have asthma?……………………………..	☐	☐
22. Had mononucleosis in the past year?…..	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Ever had an eating disorder?……………	☐	☐
25. If female, have an abnormal menstrual history?………………………	☐	☐
26. Ever had emotional difficulties for which professional help was sought?….	☐	☐

Please explain any "yes" answers, noting the number of the questions. (use additional pages if necessary)

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____

____

 Camper Name ______________________________

OTHER CAMPER INFORMATION

We want your camper to have the best possible experience while at Camp St. Herman. All information is regarded as STRICTLY CONFIDENTIAL and will only be shared with staff who work with your camper and other necessary personnel (Camp Director, Nurse, Food Service Director, etc.) as appropriate.

- Are there special fears, worries or concerns your child has about camp (extreme shyness, afraid of the dark, etc.)?

____

- Are there circumstances in your child's life that would be helpful for us to be aware of (i.e., death of a close relative, divorce, or other family trauma, etc.)? Please provide relevant details.____

____

____

- My camper is under the legal custodial care of: ☐ Both Parents ☐ Mother only ☐ Father only

☐ Other ______________________ Please provide all relevant details: ______________________

____

Please note that if any restrictions regarding parental access to the camper are to be observed by the Camp, we must be notified via court order, addressed specifically to the Antiochian Village.

- Sleep Habits: ☐ Sleep walks ☐ Wets bed ☐ Other:______________
- Dietary restrictions: ☐ None ☐ Vegetarian ☐ Vegan ☐ Diabetic ☐ Other:____________

Use this space to provide any additional information about the participants behavior and physical, emotional, or mental health about which the camp should be aware. ____

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PARENT/GUARDIAN AUTHORIZATIONS, PERMISSIONS AND AGREEMENT

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer over-the-counter medications, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I understand that my insurance coverage for my child will be used as primary coverage in the event medical intervention is needed. I further understand that I will be responsible for expenses not covered by my insurance.

I understand all reasonable safety precautions will be taken at all times by Camp St. Herman and its agents during camp. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold the Antiochian Orthodox Christian Archdiocese, Camp St. Herman, its leaders, employees, and/or volunteers liable for damages, losses, disease, or injuries incurred by the subject of this form.

I agree that my child will abide by all the rules and guidelines set forth by Camp St. Herman for the safety and good health of the campers at camp. I also agree that if my child has to return home due to discipline violations, it will be at my own expense.

I agree to indemnify and hold harmless, the Antiochian Orthodox Christian Archdiocese, Camp St. Herman, their leaders, employees, and/or volunteers from any expenses, loses , claims, or damages incurred as a result of the acts or omissions of the subject of this form. This completed form may be photocopied for trips out of camp.

I hereby agree to indemnify and hold harmless Camp St. Herman, the Antiochian Orthodox Christian Archdiocese, their clergy, officers, directors, employees, staff and volunteers from any and all expenses, claims, costs or attorney fees incurred as a result of claims, actions and/or suits brought by me, my child or on my behalf or on my child's behalf or by anyone else as a result of any accident of injury occurring to me or my child.

I give permission for my child to participate in all camp activities, except the following (please list reason for each activity denied):

Activity	Reason for Denial of Permission
____________	______________________________
____________	______________________________

Signature of parent/guardian or adult camper/staff ______________________________

Printed Name ______________________________ **Date** ____________________

**If for religious reasons you cannot sign this, contact the camp office for a legal waiver which must be signed for attendance*

 Camper Name ______________________________

***This page of the form must be received at two weeks prior to camping session or a late fee will be assessed.**

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

I examined this individual on ________________________. **BP :** __________ **Weight:** ________ **Height:** _________

Conditions List conditions for which the above participant is receiving treatment ☐ None

____

____

____

____

Restrictions List activity restrictions ☐ None

____

____

____

Past Medical/Surgical History

____

____

____

Diet/Nutrition List dietary restrictions ☐ Eats a regular diet

____

____

____

Allergies List all allergies & reactions ☐ No known allergies

____

____

____

Treatments / Medications List treatments/medications to be continued at camp (include name, dose, frequency) ☐ None

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____

____

Additional information for health care staff at the camp: ____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

Signature of Licensed Medical Personnel: ____

Printed Name: ____________________________Date: _________________ Phone: ________________________

Address: ____ Fax: ________________________ __

For camp use only:

SCREENING RECORD Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Date screened ____________________________ Time ________________ Screened by ____________

Meds Received ____

____

Current health needs identified ____